



# REDUCING ALCOHOL-RELATED HIV RISK IN KATUTURA, NAMIBIA

## A MULTI-LEVEL INTERVENTION WITH BAR OWNERS, SERVERS, PATRONS, AND COMMUNITY MEMBERS

**AIDSTAR-One**  
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES



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### **AIDS Support and Technical Assistance Resources Project**

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### **Abstract**

The AIDSTAR-One project is receiving funds from the U.S. President's Emergency Plan for AIDS Relief, through the U.S. Agency for International Development, to conduct a 2.5-year demonstration project in Namibia—a country with high HIV prevalence and heavy alcohol use. A growing body of epidemiological and social science research links alcohol consumption with the sexual behaviors that put people at risk for HIV and other sexually transmitted infections. Formative research was undertaken to understand how bar owners, staff, patrons, and community members perceive the risks and benefits of alcohol consumption and to solicit ideas about approaches for mitigating the negative effects of alcohol. The results of the formative research are reported here.

### **Acknowledgments**

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# ACRONYMS

AUDIT	Alcohol Use Disorders Identification Test
CDC	U.S. Department of Health and Human Services Centers for Disease Control and Prevention
IRB	institutional review board
km <sup>2</sup>	square kilometers
MOHSS	Ministry of Health and Social Services
NGO	nongovernmental organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
SFH	Society for Family Health
STI	sexually transmitted infection
UNAIDS	Joint United Nation Programme on HIV/AIDS
WHO	World Health Organization



# EXECUTIVE SUMMARY

A growing body of epidemiological and social science research links alcohol consumption with the sexual behaviors that put people at risk for HIV and other sexually transmitted infections. The AIDSTAR-One project is receiving funds from the U.S. President's Emergency Plan for AIDS Relief, through the U.S. Agency for International Development, to conduct a 2.5-year demonstration project in Namibia—a country with high HIV prevalence and heavy alcohol use. This project has two goals: reducing heavy drinking and reducing risky sexual behavior among bar patrons. The project is working in Kabila, a new and rapidly growing settlement in Katutura on the outskirts of Namibia's capital, Windhoek. This report describes the methods, findings, and programmatic implications of formative research, which was carried out in the first phase of the demonstration project (May to October 2010).

The formative research was undertaken in collaboration with a number of local partners, including the Namibian Ministry of Health and Social Services, Society for Family Health, and Survey Warehouse. The objectives of the formative research were 1) to understand how bar owners, staff, patrons, and community members perceive the risks and benefits of alcohol consumption, and 2) to solicit ideas about approaches for mitigating the negative effects of alcohol. This research clarified the feasibility of each of three proposed intervention components, as follows:

- Creating an HIV- and alcohol-risk averse bar environment
- Mobilizing the community for self-regulation of bars
- Decreasing the total number of bars operating in the community by training bar owners and staff in reliable livelihoods other than alcohol production and sale.

The formative research included three methodological components: a census and mapping of all drinking venues in the community; a quantitative baseline behavioral survey with a representative sample of 500 bar patrons; and qualitative research through 42 in-depth interviews and two focus group discussions with bar patrons, owners, staff, other community members, and key leaders and stakeholders.

Findings fall into five broad themes:

1. *Community life.* Kabila is a relatively new informal settlement. Its inhabitants are overwhelmingly recent migrants from Namibia's northern regions. On the whole, Kabila offers a relatively stable and inexpensive place to live. However, many Kabila residents complain about crime, poor infrastructure, and inadequate or non-existent utilities, including water and sanitation. Most of all, interviewees spoke about the hardships caused by unemployment or underemployment. Selling alcohol is one of the few reliable sources of income; drinking alcohol is one of the few ways of coping with boredom and poverty. Alcohol has become a cornerstone of social activity and the informal economy.
2. *Patterns of alcohol use and abuse.* Bars are ubiquitous—265 bars were enumerated within Kabila's four square kilometers, and most were located in the owners' homes. Hazardous and harmful drinking was extremely common. An assessment of risky drinking based on guidance from the

World Health Organization (WHO) returned a mean score of 8 (the WHO threshold for hazardous and harmful drinking) for female bar patrons and 11 for men. The volume of alcohol consumption was also high; the largest proportion of survey participants (41 percent for men and women) reported drinking an average of three to four standard units (one beer, one glass of wine, or one shot of spirits) on a typical drinking day. About one-fourth of women and over one-third of men reported binge drinking two to four times per month. Violence was also linked with alcohol use and was reportedly common at bars. Both men and women reported an increase in intimate partner violence after drinking.

3. *HIV knowledge, attitudes, and sexual behaviors.* While survey responses indicated general understanding of HIV risks and the protection offered by condoms, they also showed that risky sex was common. While over 90 percent of respondents reported that they felt in control about whether they used a condom, only 28 percent of women and 10 percent of men thought it likely that they would use a condom after they or their partner had been drinking alcohol. About one-third of respondents mentioned exchanging sex for alcohol (38 percent of the time for men and 25 percent of the time for women), and survey participants clearly linked going to bars with sexual opportunity. Nearly half of men went to a bar looking to meet a sexual partner, and over one-third of respondents felt that it was possible to find people willing to exchange money or drinks for sex in bars.
4. *Linkages between alcohol use and HIV risk.* Most bar owners expressed a lack of empowerment to promote HIV risk reduction within their bars. Providing free condoms was the only strategy they mentioned for reducing risk. Bar patrons participating in the interviews did not feel that bar owners would be willing to stop serving people who are already drunk (a key strategy in reducing harm from drinking). For their part, bar owners largely felt that patrons should be responsible for their own drinking behavior. All respondents mentioned that bars in Kabila are open too late, generally attributing this to the absence of regulation and enforcement of laws on alcohol use. Survey participants felt that establishing a closing time or limiting hours of services could reduce the problems associated with alcohol, including heavy drinking, violence, and noise.
5. *Alcohol as a livelihood strategy and potential alternatives.* Bars provide the most profitable income-generating activity in Kabila, but the profits are not high. Relatively low start-up costs and inputs create the perception that owning a bar is highly profitable. Bar owners and staff expressed interest in skill-building opportunities to strengthen their livelihood strategies.

The formative research suggested many programmatic implications that will inform the development of the pilot intervention. The findings clarified the feasibility of the three components originally proposed.

*Creating an HIV- and alcohol-risk averse bar environment:* The data clearly indicate the need to reduce risks within the bar environment. Training on safe alcohol serving and HIV risk reduction will give bar owners the knowledge and skills to communicate with their clients about hazardous alcohol consumption and safer sex. Bar owners may also reduce risks in their establishments by diversifying the range of products for sale, developing strategies to ensure condom availability, and replacing or augmenting alcohol advertisements with information about hazardous alcohol consumption and HIV risk reduction.

*Mobilizing the community for self-regulation:* The data also highlight the need for community involvement and mobilization around alcohol. Community members and bar owners were unable to suggest strategies or ideas for mitigating the effects of alcohol beyond direct governmental intervention. However, in the absence of regulatory oversight by the government, communities themselves must

self-regulate, which implies examining the effects of alcohol consumption on individuals and the community, setting expectations about how bars will operate, and holding bar operators to those expectations. By facilitating community mobilization, and building community members' capacity to advocate for their collective interests, the project can begin to address the context in which hazardous drinking occurs in Kabila. A helpful first step may be a community action forum in which these issues could be addressed. Forum activities could include community enforcement of hours of operation, creation of alternatives to drinking, such as recreational activities, or organizing neighborhood businesses to explore cooperative initiatives.

*Alternative livelihoods:* Finally, the formative research showed that those selling alcohol often lack the skills, training, or capital to find safer, more sustainable sources of income. Working with local training entities to explore alternative livelihoods for bar owners is a potential strategy to address this, but it would require intensive financial resources. While an alternative livelihoods intervention may hold promise, the findings from the formative research lead to the conclusion that it is not feasible to pursue as part of this small pilot demonstration project.



# BACKGROUND

## ALCOHOL USE AS A RISK FACTOR FOR HIV

A growing body of epidemiological and social science research, much of it conducted in developing countries experiencing severe HIV epidemics, suggests that alcohol consumption is associated with the sexual behaviors that put people at risk for HIV and other sexually transmitted infections (STIs) (Cook and Clark 2005; Kalichman et al. 2007a). This scientific evidence justifies an urgent call to action. In countries where HIV prevalence is high, addressing harmful drinking in conjunction with interventions to reduce sexual risk behavior may help to reduce HIV transmission more effectively than conventional HIV prevention interventions alone.

Key findings from seminal research on the intersection of alcohol and HIV show that in developing countries, alcohol use and HIV risk behavior are strongly associated. A number of surveys have found that people who drink alcohol engage in unprotected sex, multiple partnering, and commercial sex more often than do non-drinkers.

Drinking venues themselves have also been associated with HIV risk, because they provide opportunities both to drink alcohol and meet casual sex partners. In rural eastern Zimbabwe, a population-based survey of nearly 10,000 women and men showed that visiting a beer hall in the last month was associated with risky behavior and with HIV infection (Lewis et al. 2005). In Cape Town, South Africa, men and women who met sex partners at informal bars (*shebeens*) engaged in heavier drinking, had more sex partners, and had higher rates of unprotected sex compared to people who did not meet sex partners at shebeens (Kalichman et al. 2008).

The causal pathways linking alcohol use and sexual risk-taking are still being investigated. Recent psychological research highlights the pharmacological properties of alcohol, which decreases cognitive capacity to accurately judge risk while increasing attention to sexual arousal (Davis et al. 2007; George and Stoner 2000). Additional research has shown that alcohol use before sex may be motivated by a person's expectation that alcohol will improve enjoyment of sex or sexual performance (Kalichman et al. 2006, 2007b).

Social science research has also revealed gender-related links between sexual risk-taking and alcohol use. A study of risky drinkers recruited from bars in Johannesburg and Pretoria, South Africa, showed that men's drinking was heavily influenced by peers and was characterized mainly as a sensation-seeking and stress-reducing activity (Morojele et al. 2006). Importantly, this research also showed that for men, the capacity to drink heavily and engage in sex with multiple casual partners symbolized masculinity. For women, drinking was an opportunity to seek male companionship—particularly that of older men. Social vulnerability as an underlying determinant of alcohol use and sexual risk among women emerges strongly from the research. A rapid situation assessment of sexual risk behavior and substance use among sex workers in Chennai, India, for example, showed how women consumed alcohol to cope with personal histories of abuse and neglect and numb themselves emotionally to their work (Kumar 2003).

# HIV AND ALCOHOL IN NAMIBIA

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), Namibia had 180,000 adults and children living with HIV in 2009—an estimated HIV prevalence of 13.1 percent (UNAIDS 2010). Young women and young men (aged 15 to 24 years) reported that they used a condom at last sex 66 percent and 74 percent of the time, respectively (UNAIDS 2008).

Alcohol consumption is high, and increasing, in Namibia (World Health Organization [WHO] 2011). Data from 2003 to 2005 showed that annual alcohol consumption in Namibia per capita was 9.6 liters, well over the average consumption in Africa (6.2 liters). Furthermore, 3.7 of the liters consumed in Namibia are unrecorded alcohol.<sup>1</sup> The patterns of drinking score<sup>2</sup> for Namibia is 3, on a scale of 1 (least risky) to 5 (most risky). This is similar to neighboring countries in Southern Africa.

## A DEMONSTRATION PROJECT TO ADDRESS ALCOHOL-RELATED HIV RISK BEHAVIOR IN NAMIBIA

Given Namibia's high prevalence of HIV and risky alcohol use, AIDSTAR-One is conducting a pilot demonstration project with the dual goal of reducing both heavy drinking and risky sexual behavior among bar patrons. This demonstration project is part of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Interagency Alcohol Initiative—a collaboration between the Centers for Disease Control and Prevention (CDC) and U.S. Agency for International Development offices in Namibia, the Namibian Ministry of Health and Social Services (MOHSS), the National Technical Advisory Committee on Prevention, the Alcohol-HIV Workgroup of the Technical Advisory Committee, and other nongovernmental stakeholders. The PEPFAR Interagency Alcohol Initiative promotes a comprehensive strategy to address individual-, community-, and environmental-level change using best practices from health policy, behavioral science, epidemiology, addiction treatment, and development approaches. This project contributes to the PEPFAR Interagency Initiative's mandate to demonstrate how community- and environmental-level approaches can positively influence HIV risk behavior for individuals. The project location is Katutura, a peri-urban, low-income area on the outskirts of Namibia's capital city, Windhoek.

Like South Africa's Soweto, Katutura is a large (approximately 30 square kilometers [km<sup>2</sup>]) former township where black Namibians were forced to live during apartheid, and which presently contains several administrative constituencies. Home-based brewing and sale of alcohol are ubiquitous in Katutura, and bars, many of them unlicensed, are among the few sources of steady income. The pilot demonstration project will take place in Kabila, a new settlement occupying about 4 km<sup>2</sup> on the outer edge of Katutura. Kabila is growing rapidly due to migration from rural areas; its exact population is undocumented.

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<sup>1</sup> Unrecorded alcohol refers to alcohol that is not taxed and is outside the usual system of governmental control because it is produced, distributed, and sold outside formal channels. Unrecorded alcohol consumption in a country includes consumption of homemade or informally produced alcohol (legal or illegal), smuggled alcohol, alcohol intended for industrial or medical uses, alcohol obtained through cross-border shopping (which is recorded in a different jurisdiction), as well as consumption of alcohol by tourists. Homemade or informally produced alcoholic beverages are mostly fermented beverages made from sorghum, millet, maize, rice, wheat, or fruits.

<sup>2</sup> From the WHO Global Status on Alcohol and Health Report: The patterns of drinking score reflects *how* people drink instead of *how much* they drink. Strongly associated with the alcohol-attributable burden of disease of a country, the patterns of drinking score is measured on a scale from 1 (least risky pattern of drinking) to 5 (most risky pattern of drinking). The higher the score, the greater the alcohol-attributable burden of disease. Notably, different drinking patterns give rise to very different health outcomes in population groups with the same level of consumption.



View of Kabila. (Photo courtesy Robyn Hayes)

This 2.5-year demonstration project focuses on low-income communities with an extremely high density of alcohol outlets and high levels of both hazardous drinking and risky sexual behavior. The project's original concept brief suggested three evidence-based strategies for the pilot intervention (Cohen et al. 2006; Friedman and O'Reilly 1997; Livingston, Chikritzhs, and Room 2007; Sweat and Denison 1995):

- 1. Creating an HIV-risk averse bar environment.** Encouraging and sustaining behavior change among patrons may require creation of risk averse bar environments. This strategy entails two components: 1) training bar owners and staff to serve alcohol more safely and to educate patrons on the hazards of excessive alcohol consumption and how to reduce HIV risk; and 2) physically altering the bars to make them more conducive to moderate alcohol consumption and HIV risk reduction.
- 2. Mobilizing the community for self-regulation.** This strategy entails mobilizing community members to critically examine the effects of alcohol consumption on the community's well-being, and develop strategies to support safer alcohol selling practices. Such a strategy may be particularly important where bars are unlicensed and unregulated. A community action forum could be established to address these issues.
- 3. Decreasing the total number of bars operating in the community by promoting alternative livelihoods.** This strategy would help alcohol sellers identify alternative trades and move out of alcohol sale and into other businesses that could provide a better income without harming community health. The intervention team could work with local vocational training centers and nonprofit organizations to refer participating bar owners for training in alternative livelihoods.

The formative research, carried out in the first phase of the demonstration project, explored the feasibility of each of these three approaches and provided input on how to structure the final intervention. This report describes the implementation, findings, and implications of the formative research.



# OBJECTIVES

The objectives of the research were to 1) identify how bar owners, staff, patrons, and community members perceived the risks and benefits of alcohol consumption to individuals and the community; and 2) solicit ideas from community members and other stakeholders about approaches for mitigating the effects of alcohol. A key theme throughout the qualitative interviews was the role of alcohol production and sale in the local informal economy and within individuals' livelihoods. It was essential to understand how communities viewed alcohol production and sale as a business activity, what other livelihood options exist, why individuals would choose the alcohol trade rather than other income-generating activities, and whether their alcohol-related business would affect their willingness to participate in an HIV prevention program. The study included three major components:

1. Census and mapping of all bars and drinking venues in Kabila (May 2010) provided a sampling frame for the survey and identified settings where risky drinking and sexual behavior occurs. The census and mapping documented the density of bars.
2. The baseline survey (June to July 2010) described the demographic and risk profile of those targeted in the intervention, informed the intervention design, and will be used to measure behavioral change outcomes when the intervention ends. The survey, developed by the AIDSTAR-One team and a local research firm, Survey Warehouse, provided information on demographics, the prevalence of hazardous alcohol use, sexual risk behaviors, and experiences of violence related to drinking among a representative sample of bar patrons ( $n = 500$ ).
3. The qualitative research (September to October 2010) was designed to clarify community perceptions about alcohol use in the community and to determine the feasibility of introducing an alternative livelihoods component into the pilot intervention. This research was essential to understanding how to design an intervention that mobilizes the community to promote behavior change.

The AIDSTAR-One team conducted this research in collaboration with the Namibian MOHSS and the Society for Family Health (SFH), a local nongovernmental organization (NGO) with expertise in maternal and child health, malaria, and the prevention, care, and treatment of HIV. SFH and AIDSTAR-One will also collaborate on the project implementation. Survey Warehouse, a local research firm, assisted in the enumeration and mapping of bars and the administration of the behavioral survey.



# METHODOLOGY

## CENSUS AND MAPPING OF BARS AND DRINKING VENUES IN KABILA

Mapping and enumeration began with the development of a data collection form to document the location and characteristics of all bars—defined as a place where alcohol was sold and consumed—located within Kabila. The Namibian government requires bar owners to obtain and display a license, but the licensing process is cumbersome and expensive; most small bars, such as those in Kabila, are unlicensed. Using maps of the area provided by the Windhoek police department, three teams of data collectors from Survey Warehouse collected information about the bars—including the number and location of bars, the types of alcohol sold, other products sold, and the gender of the owners and employees of the bars. The enumeration data were used as the sampling frame to select bars for participation in the survey; the mapping data were necessary for locating the bars again. A total of 265 bars were enumerated over the course of three days in May 2010.

## QUANTITATIVE BASELINE SURVEY

**Participant recruitment:** The research team sought to ensure that a representative sample<sup>3</sup> of at least 500 bar patrons participated in the baseline survey. The objective was to recruit a sample of patrons that would closely mirror patrons who visit bars in Kabila in terms of age, socioeconomic status, drinking, and sexual behavior patterns. The team chose the time-location sampling methodology, which uses a random selection of venues and individuals within those venues as a proxy for randomly selecting from the population. Time-location sampling is recommended when it is known that a large proportion of the target population can be reached at discrete sites, and when no comprehensive census of the target population exists. Also, time-location sampling has been implemented relatively easily in bar environments in sub-Saharan Africa (Raymond et al. 2007). This method involves randomly ordering bars into a calendar of recruitment events lasting four hours each. Recruiters visit the bar and intercept a random selection of patrons, inviting each to participate in the survey. For the time-location sampling method, 500 respondents are considered an adequate sample to capture a 15 percent change in behavior from baseline to endline.

**Survey development:** The survey was developed in English using or adapting questions from previous surveys validated for similar work. The survey was then translated into Oshiwambo and Afrikaans, the two most commonly spoken languages in Kabila. Survey questions were drawn from the International Men and Gender Equality Survey instrument (Section 7); the WHO Multi-Country Study on Women’s Health and Domestic Violence (Section 9); surveys from the Medical Research Council of South Africa’s study in bars and shebeens in Pretoria, South Africa; the survey used for the Harare Beer Hall HIV Prevention Study carried out by Katherine Fritz (Sections 4 to 6, 8, and

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<sup>3</sup> Sample size was calculated using an estimated prevalence of “drunk at last sex” to be anywhere from 30 to 60 percent, adjusted for a 20 percent refusal rate with a 95 percent confidence interval with a width of 9 percent, and adjusting for a design effect of 1.67 (the overall design effect estimated from the last Namibian Demographic and Health Survey) given that the survey clustered on the bar.

10 to 12); and the WHO Alcohol Use Disorders Identification Test (AUDIT) as adapted and previously tested for use in Katutura (Section 2).

**Data collection:** Survey data collection began in late May 2010 and continued through the end of June. Of the 500 survey participants, 301 were men and 199 were women, reflecting the fact that bar patrons are largely men; to get a representative sample of bar patrons, the sampling strategy could not stratify by gender. Each team visited their assigned bar for the day. After obtaining the bar owner's permission to conduct the research, the team members introduced themselves and the survey to the patrons in the bar and determined the eligibility<sup>4</sup> of those interested in participating. When more people were interested than could be interviewed at a given time, two people were randomly selected by asking them to select colored rocks from a bag, and the others were invited to come back later during the four-hour period.

Once interest and eligibility were determined, the interviewer and participant moved to a safe and private area near the bar that was predetermined by the interviewer and field supervisor. The interviewer then administered written informed consent and, if the participant agreed, conducted the survey. Survey participants were given 10 Namibian dollars (U.S.\$1.33) of cellular air time for their participation. This is the same reimbursement that was provided for surveys conducted in Katutura by CDC/Namibia and deemed appropriate because the reimbursement is small enough for the research staff to carry with them. To avoid interviewing the same person more than once, interviewers asked the participant if they had already been interviewed as part of this study. Following institutional review board (IRB) procedures, informed consent forms were signed and kept separate from the surveys in a locked cabinet at the research firm. The surveys were assigned identification numbers but included no personally identifying information.

Recruitment information was recorded on tracking sheets. Of the 722 people found in the bars during the entire recruitment period, 79 percent were found to be eligible ( $n = 570$ ) and 88 percent of those eligible agreed to participate ( $n = 500$ ).

Data analysis was conducted using SPSS (PASW Statistics 18, Release 18.0.0, July 30, 2009). Frequencies were examined using cross-tabulations and separating responses by men and women. Total frequencies of responses across gender were also examined. This descriptive analysis provides information about the background characteristics, alcohol use, HIV risk behaviors, violence, and sexual health of survey participants.

## QUALITATIVE (IN-DEPTH) RESEARCH

The research team conducted a total of 36 in-depth interviews and two focus group discussions. The AIDSTAR-One study team trained four data collectors in research ethics and qualitative research, including skills for conducting in-depth interviews and focus group discussions. Three of the data collectors were social workers from MOHSS and the fourth was a member of the research staff at SFH.

**Participant recruitment:** Equal numbers of men and women were purposively selected according to the following categories: bar owners, bar servers, bar patrons, and community members. Community leaders and stakeholders were selected with information from the local constituency councilor (the representative of the administrative region that includes Kabila), who also disseminated information about the project on the radio. Other key informants included officials

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<sup>4</sup> To be eligible to participate in the survey, the person had to be 1) a patron at the bar (not the owner or employee); 2) over 18 years of age; and 3) able to provide informed consent (not intoxicated or otherwise cognitively impaired).

from MOHSS, the Ministry of Gender Equity and Child Welfare, and the Namibian Shebeen Owners Association.

**Development of interview and focus group guides:** AIDSTAR-One worked with the local research team to develop and revise two different types of interview guides for the field work—one for interviews covering general information about the community, views about the relative risks and benefits of alcohol consumption, the strengths and weaknesses of bar ownership as a livelihood strategy, and suggested strategies for reducing alcohol-related harm through bar-based or community mobilization efforts. The second interview guide was designed for more in-depth discussions on alcohol selling as a livelihood. Each guide was developed and revised based on feedback from the local research team, and adapted for the type of participant (bar owner or server, patron, or community member). The livelihood strategies guide was used with a smaller number of participants and documented the range and combination of the mostly informal income-generating activities and investment strategies used in Kabila. These data helped determine the feasibility of including a livelihoods component within the intervention.

**Data collection:** The data collectors recruited a convenience sample of participants from different parts of Kabila each day. The remaining interviews with stakeholders were scheduled and completed by the end of October 2010. A total of 36 people participated in the in-depth interviews, and two focus group discussions were completed with a total of 11 individuals. Twenty-six in-depth interviews and both focus group discussions were conducted with people living in Kabila. The research teams also conducted 10 in-depth interviews with male and female stakeholders not living in Kabila, including a city police officer, a constituency councilor, a staff member from a local NGO working on health issues including HIV, Katutura community leaders, and officials from governmental and municipal agencies. These interviews helped to confirm and explain information shared by people living in Kabila. Table 1 summarizes the qualitative research participants by gender and by method of data collection.

**Table 1. Qualitative Research: Number of Men and Women Participating in Interviews and Focus Group Discussions**

	<i>Interviews on Community Views*</i>		<i>Interviews on Livelihoods Exclusively</i>		<i>Focus Group Discussions</i>	
	<i>Men</i>	<i>Women</i>	<i>Men</i>	<i>Women</i>	<i>Men</i>	<i>Women</i>
<b><i>Kabila bar owners</i></b>	4	4	1	1	0	0
<b><i>Kabila bar patrons</i></b>	2	2	1	1	0	0
<b><i>Kabila bar servers</i></b>	2	2	1	1	0	5
<b><i>Other Kabila community members</i></b>	1	1	1	1	3	3
<b><i>Non-Kabila stakeholders</i></b>	6	4	0	0	0	0
<b><i>Totals</i></b>	<b>15</b>	<b>13</b>	<b>4</b>	<b>4</b>	<b>3</b>	<b>8</b>

\* Included questions about livelihoods.

All interviews and focus group discussions were transcribed and translated into English. The English transcripts were then coded by topic using ATLAS.ti according to the main themes of the study. Additional themes arising from the data were identified and coded accordingly.

**Ethical considerations:** The study was approved by the IRB of the Namibian MOHSS and that of the International Center for Research on Women, the AIDSTAR-One partner organization leading this research. Permission to work in Kabilia was granted by the constituency councilor and community-level local leaders. Signed informed consent was obtained from all study participants who volunteered. All participants consented for interviews to be recorded on tape. Tapes and transcripts are only available to the research team and contain no identifying information.

# STUDY FINDINGS

The research findings combine qualitative and quantitative data and cover five broad themes, as follows:

1. **Community life in Kabila.** Data from these findings provided details about the lives of Kabila residents, how they fit within the larger communities of Katutura and of Windhoek, and what issues (including alcohol) Kabila residents found most important. Researchers used the data to determine the feasibility of conducting community mobilization around alcohol in ways that reflect residents' concerns.
2. **Patterns of alcohol use and abuse.** Information on alcohol use and its impact on the community gives a fuller picture of the severity and patterns of problematic alcohol use and will help to design the content of the bar owner and server trainings and to provide referrals for people with alcohol dependency. This in-depth examination will inform the community mobilization component by shedding light on individuals' motivations for drinking.
3. **HIV knowledge, attitudes, and behaviors.** It is important to understand perceptions of HIV among the target community to develop interventions that meet the specific risk profile of this group.
4. **Addressing the linkage between alcohol use and HIV risk.** These data show how interview participants felt that hazardous alcohol consumption and related HIV-risk behaviors are currently being or should be addressed.
5. **Alcohol selling as a livelihood and alternatives.** A clear understanding of the employment options and challenges for Kabila residents—including infrastructure and civic support, gender concerns, and preferred livelihoods—will help to develop and assess the feasibility of an appropriate component for developing healthier alternative livelihoods.

## COMMUNITY LIFE IN KABILA

*I wouldn't say the place is bad, but it has its disadvantages: there is no electricity, but we have water. We are just here for survival.*

*—Male bar owner, in-depth interview*

**Migration, infrastructure, and services:** Kabila, as described previously, is a relatively new informal settlement on the outskirts of Katutura. Its affordability is a primary factor in the settlement's rapid growth. Nearly all of the research participants said that they had moved to Kabila within the last two years, mostly from elsewhere in Katutura or from northern Namibia; only a few had lived there for more than five years. On the whole, Kabila offers a relatively stable and inexpensive place to reside. Water is provided through a communal tap, and its cost is generally within reach. People either moved from neighboring locations in Katutura or from the northern part of the country ("the North").

*I came from the North, first I was staying with my relative then later I made my own house. I need money; I just came here to look for a job to help myself and others. This is the place I can afford. I have nowhere to go.*

*—Male bar owner, in-depth interview*

Some people also mentioned that they were living in nearby locations that were crowded and told by the municipality to move.

*[Before Kabila] I stayed in Freedom Square (another location). There I stayed at someone's house but the person retired from work and then he decided to sell his house...I did not have a place to go because I have a lot of kids to rent a house. Because I couldn't afford it there, I have decided to come to Kabila.*

*—Male community member, in-depth interview*

To live in Kabila, people must register with the Windhoek municipality and are then assigned a piece of land (an *erf*)<sup>5</sup> where they can build their home. However, participants struggle with becoming formal homeowners: most are waiting to be given permission to live on the land by the municipality.

*They just put us here, they were saying they will give us erfs, but until now they didn't do anything. Still we don't know if we will stay here or they will shift us again. Now that makes us hate this place because we don't know if it's our own place or if they will remove us again.*

*—Male bar owner, in-depth interview*

The residents of Kabila experience extremely challenging living conditions, all of which reinforce their socioeconomic vulnerability. In Namibia, as in other southern African countries, rural-urban migration has led to overcrowded peri-urban spaces, resulting in a public service crisis (Drimie, 2008). Many Kabila residents complain about the infrastructure, including the lack of toilets, regularly functioning water taps, and electricity. The sense of deprivation affects people's perception of well-being.

*You know, Kabila is a location that is a little bit far from everything...it's like we are cut off or we are abandoned from all the required services that a person needs, like electricity.*

*—Male bar owner, in-depth interview*

Many participants link criminal activity to the lack of infrastructure.

*Just look at the toilet—it's far—see that blue one? The thief will meet us [when] we come from the toilet. Even this one day one person was killed coming from the toilet. We don't have electricity. We just use candles. It's very dark.*

*—Male bar owner, in-depth interview*

Finally, the rates of rural-urban migration have greatly surpassed urban job creation, exceeding even the capacity of the informal sector to absorb workers (Drimie 2008). All interviewees mentioned unemployment and lack of opportunities for professional and personal development, both as a national issue and as a direct experience of community members in Kabila.

The lack of economic opportunities and physical insecurity resulting from recent migration leads to a sense of helplessness and frustration among most Kabila interviewees and is an important backdrop to the issues that this project seeks to address. Feelings of isolation and abandonment arise from living in a place with limited access to jobs and services. Within this environment, selling

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<sup>5</sup> *Erf* is the Afrikaans word for plot of land. People are assigned an *erf* by the municipality. The municipality has to provide services to the *erf* before people are able to buy it. In most of Kabila, the *erfs* have not yet been serviced so people are waiting to buy them.

alcohol is one of the only reliable sources of income. Thus, alcohol has become a cornerstone of the informal economy, leading to alcohol abuse and related risky sexual behavior.

**The role of the state, the municipality, and civil society in community life:** Interviewees from Kabila showed a marked perception of an absence of civil organizations of any kind. A few interviewees identified the local government and churches as the only potential sources of support to the community. While this seems to reflect a certain degree of trust in the government, participants often expressed frustrations that the government is not providing adequate economic opportunities.

While most people feel that the local government may have the power to resolve issues in the community or provide it with support, they do not feel that there is a will to help.

*People meet and bring proposals together but there is no power as I told you, there is a lot of unemployment as there is no power, people have nowhere to go. We meet and talk but for those things we discuss, there is no help. There is no money and other things. There is no electricity. Even if we come up with a proposal and take it to the council office there will be no help.*

*—Male bar staff, in-depth interview*

Some people were not aware of the identity of their councilor and mentioned only church groups working in Kabila.

One interviewee highlighted the problem of communication between multiple levels, starting with community-level committees all the way up to the municipality. In addition to the lack of institutional presence in Kabila, there is no formal credit or loan system available. Access to credit requires guarantees, such as regular employment and collateral, which most Kabila residents lack.

Nonetheless, some residents in Kabila—mostly women—are members of an informal loan system in which they jointly invest regularly (usually monthly) and benefit from on a rotating basis.

*I just help myself. We make our party by putting money together like a “stockveld group” every month. We put N\$250.00 (U.S.\$33) each and we are five... Yes, the most income I am getting is the stockveld party that we are involved... at end we make N\$1,000.00 (U.S.\$133) per person’s turn... We usually start in February. The first person she buys drinks and puts it in her bar. Then she sells (drinks) and meat. Then people come to support and we as a group put N\$150.00 (U.S.\$20) per person then we put it all together and if she counts the money it will be N\$1,000.00 (U.S.\$133). It’s how we do it.*

*—Female bar patron, in-depth interview*

The overall lack of confidence in governmental institutions and the absence of civil society organizations make it difficult, if not impossible, for Kabila residents to feel they are part of a functional community that can identify and resolve its collective problems. The overarching sense of apathy is a formidable barrier to any community mobilization effort. Furthermore, in the qualitative interviews, participants were not able to provide suggestions about how the community could address or mitigate the effects of alcohol. The suggestions that were offered were primarily related to governmental intervention, such as police enforcement of operating hours, which was found to be lacking. To be successful, community mobilization will require a renewed effort by both community members and their governmental representatives to work together more effectively, and to creatively identify financial and intellectual resources available to the community. The informal rotating savings system demonstrates that collective strategies can and do exist. Building on the spirit and organization of these types of collectives may be an effective strategy for mobilizing communities for the intervention.

## PATTERNS OF ALCOHOL USE AND ABUSE

The formative research yielded a large amount of data on drinking and related sexual risks. This information will help design a targeted intervention and track changes that result from the intervention.

**Bars in Kabila:** Most of the 265 bars mapped in Kabila were in the owners' homes, with a main room serving as the bar area and bedrooms off of that main room. The bars often had metal bars from the countertop to the ceiling for protection. The items for sale are kept on the shelf beyond the counter. These may include bottles of wine, home brewed beer, or spirits. The beer and spirits are kept in barrels and served in a pitcher; glasses are usually shared among patrons. In many bars, non-perishable food items such as chips and biscuits are also for sale in limited quantities, in addition to other household items such as matches or toilet paper. Larger bars sometimes had pool tables, jukeboxes, and/or gambling machines—often not the property of bar owners—that are used to draw in business. Bar owners rely on generators to cool the drinks or run the gambling machines, jukeboxes, or radios. Only one of the bars visited had a toilet with indoor plumbing.



Community outreach workers inside a shebeen in Katutura.  
(Photo courtesy of Katherine Fritz, International Center for Research on Women)

**Demographics:** The baseline survey demographic data shows that bar patrons tend to be young adults with some secondary education who are in a primary relationship but not yet married, and who have spent most of the last year living in the community. Furthermore, male bar patrons interviewed had twice the income of women in the last month (see Table 2). Findings from the in-depth interviews supported this finding.

**Reasons for drinking:** In Kabila, people reported a wide range of reasons for drinking alcohol on an agree-disagree (two-point) rating scale.<sup>6</sup> More than half of the bar patrons surveyed agreed that they worry less (53 percent) and feel more confident when they drink (54 percent; see Table 3). Drinking also relieved boredom in more than half of respondents. Findings from the in-depth interviews echoed those of the baseline survey.

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<sup>6</sup> The alcohol expectancy items were drawn from the 120 items included in the Alcohol Expectancy Questionnaire developed and validated by Mark S. Goldman, PhD.

**Table 2. Characteristics of Study Population in Baseline Survey**

	<b>Female (n = 199)</b>	<b>Male (n = 301)</b>	<b>Total (n = 500)</b>
<b>Mean age (range, standard deviation)</b>	29.7 (18–62, 8.0)	31.7 (18–70, 10.6)	30.9 (18–70, 9.7)
<b>Highest level of schooling</b>	(n = 199)	(n = 298)	(n = 497)
None	1.5%	3.0%	2.4%
Some primary	14.1%	11.7%	12.7%
Completed primary	14.6%	12.8%	13.5%
Some secondary	42.7%	45.0%	44.1%
Completed secondary	26.1%	25.2%	25.6%
Vocational training	0.5%	1.3%	1.0%
Tertiary diploma/degree	0.5%	1.0%	0.8%
<b>Average amount earned last month (Namibian dollars/U.S. dollars)</b>	N\$886.71 U.S.\$117.00	N\$1,799.45 U.S.\$237.00	N\$1,436.18 U.S.\$189.00
<b>Relationship status</b>			
Single/never married	10.6%	18.6%	15.4%
In a relationship (not living with partner)	39.4%	32.9%	35.5%
In a relationship (living with partner)	34.8%	27.6%	30.5%
Married	11.1%	15.3%	13.6%
Separated/divorced	2.0%	1.7%	1.8%
Widowed	2.0%	4.0%	3.2%
<b>Number of months spent in current location in past 12 months</b>	10.6	10.6	10.6

**Table 3. Alcohol Expectancy: Percent of Respondents Agreeing with Each Statement by Gender**

	<b>Female (n = 199)</b>	<b>Male (n = 301)</b>	<b>Total (n = 500)</b>
<b>You feel powerful when you drink, as if you can really influence others to do what you want.*</b>	39.2	60.8	52.2
<b>Drinking gives you more confidence in yourself.*</b>	45.7	60.1	54.4
<b>When you feel high from drinking, everything seems to feel better.*</b>	41.2	53.5	48.6
<b>Drinking helps you not to feel bored.</b>	56.3	59.8	58.4
<b>Drinking makes the future seem brighter.*</b>	19.1	32.2	27.0
<b>You drink when you are feeling angry.</b>	35.2	33.2	34.0
<b>After a few drinks, you feel brave and more capable of fighting.</b>	29.1	30.2	29.8

	<b>Female (n = 199)</b>	<b>Male (n = 301)</b>	<b>Total (n = 500)</b>
<b><i>Drinking can make you more satisfied with yourself.</i></b>	47.7	56.1	52.8
<b><i>Alcohol helps you sleep better.</i></b>	47.2	48.2	47.8
<b><i>You are a better lover after a few drinks.</i></b>	35.2	41.7	39.1
<b><i>Alcohol makes you feel better physically.*</i></b>	34.2	47.2	42.0
<b><i>Alcohol makes you worry less.*</i></b>	45.7	58.5	53.4

\*Difference between men and women significant at  $p < 0.05$ .

**Hazardous alcohol use and dependency:** The WHO AUDIT tool, adapted to reflect local customs and beverages, was used to assess alcohol dependency among survey participants. AUDIT provides information about patrons' drinking behavior (quantity and frequency) while also measuring the levels of hazardous drinking and alcohol dependency. WHO guidelines stipulate that scores of 8 or higher indicate hazardous and harmful alcohol use.

Among people surveyed for this project, individual scores ranged from 1 to 32 (out of a possible 40), and the median AUDIT score for women was 8 and for men was 11. Both scores indicate hazardous levels of alcohol consumption, and suggest that risky drinking is common in this population.

The responses to AUDIT questions can be looked at separately to gain insight about which behaviors contribute to the overall AUDIT score and which behaviors should be targeted for intervention activities (see Table 4).

- *Frequent drinking:* While women generally reported lower frequency and levels of consumption, a similar proportion of women and men said that they drank four or more times per week (15 percent of women and 14 percent of men).
- *Quantity consumed:* The largest proportion of both men and women (41 percent) reported drinking an average of three to four standard units (one 340-milliliter beer, one glass of wine, or one shot of spirits) on a typical drinking day.
- *Binge drinking (drinking more than six standard drinks on one occasion):* Binge drinking is more common among men than women in general, but about one-fourth of women and over one-third of men (22 percent and 37 percent, respectively) reported binge drinking two to four times per month. A small but alarming percentage of respondents (6 percent of women and 8 percent of men) reported binge drinking four or more times per week.
- *Hazardous drinking:* A significant proportion of men and women (15 percent) also reported hazardous drinking—being unable to stop drinking after beginning—on a monthly basis.

Table 4 summarizes responses to AUDIT questions.

**Table 4. WHO AUDIT: Scores and Selected Responses by Men and Women in Kabila\***

	<b>Female</b>	<b>Male</b>	<b>Total</b>
<b>Audit score (possible score of 0–40)</b>	(n = 153)	(n = 244)	(n = 397)
Mean	8.99	11.58	10.58
Median	8.00	11.00	10.00
Range	1.0-28.0	1.0-32.0	1.0-32.0
	<b>Female</b>	<b>Male</b>	<b>Total</b>
<b>Frequency of alcohol consumption (%)</b>	(n = 198)	(n = 301)	(n = 499)
Never	19.2	16.6	17.6
Once a month	26.8	17.6	21.2
Two to four times a month	25.3	34.6	30.9
Two to three times a week	14.1	17.6	16.2
Four or more times a week	14.6	13.6	14.0
<b>Standard units consumed (%)</b>	(n = 160)	(n = 253)	(n = 413)
0 to 2	35.0	27.3	30.3
3 to 4	40.6	40.7	40.7
5 to 6	15.0	17.0	16.2
7 to 0	4.4	5.9	5.3
10 or more	5.0	9.1	7.5
<b>Frequency consumed 6 or more drinks on one occasion (%)</b>	(n = 161)	(n = 252)	(n = 413)
Never	30.4	7.1	16.2
Once a month or less	33.5	26.6	29.3
Two to four times a month	22.4	36.9	31.2
Two to three times a week	8.1	21.4	16.2
Four or more times a week	5.6	7.9	7.0
<b>Frequency unable to stop drinking after starting in past 12 months (%)</b>	(n = 161)	(n = 252)	(n = 413)
Never	64.0	51.6	56.4
Less than monthly	15.5	24.2	20.8
Monthly	11.2	17.1	14.8
Weekly	6.2	5.6	5.8
Daily or almost daily	3.1	1.6	2.2

\* Note, the total number of respondents differ throughout the table because AUDIT scores can only be calculated for individuals who responded to all questions. Some individuals refused to answer certain questions.

**Violence and other negative effects of alcohol:** While poverty, unemployment, and disenfranchisement were the pervasive problems mentioned by Kabila residents, alcohol was seen as a major issue, often related to other perceived problems in the community. In-depth interview participants mentioned alcohol as a problem in families—for example, drinkers spending their money on alcohol instead of food and household necessities. Survey participants reported that they

spend 14 percent of their monthly income on alcohol (14.0 percent for women and 13.9 percent for men).

*Kids are not able to go to school because most parents here are young. They can use all the money and they don't have money left for school fees for their kids or money to buy read[ing] for the kids. That's the big problems that occur if people use alcohol.*

—Male bar server, in-depth interview

Interviewees frequently associated alcohol use with violent behavior. Violence is common at bars. Only three percent of respondents said that violence never occurred; the majority (64 percent) reported that at some point they had felt unsafe in bars.

Community members consistently noted an association between crime and bars, connecting infrastructure problems (such as inadequate street lighting), alcohol consumption, and crime.

*There is no electricity and it's too dark, and when it is dark you are giving room to the tsotsis (thugs) so that they can at least break in [to] people's businesses and steal.*

—Male bar owner, in-depth interview

*People beat each other, break in to other peoples' houses, stabbing each other with a knife and cutting each other with glass.*

—Male bar owner, in-depth interview

Most bar owners also reported feeling unsafe, as they are the targets of theft.

*This place to sell alcohol is not safe. It's not safe at all. There is no security or anything. We just sell like that. There is no police.*

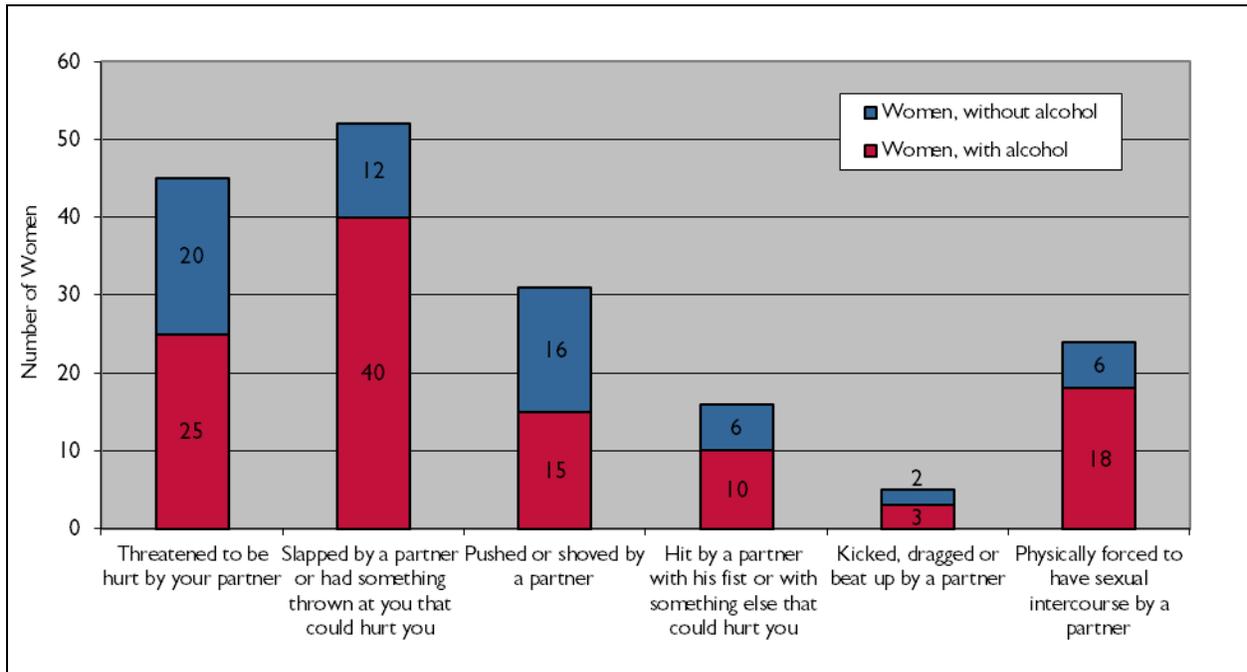
—Female bar owner, in-depth interview

*It is not protected, it is half protected. Why do I say it is half protected? The first thing is, the stuff to build the place is not strong enough, only zinc. Sometimes thieves cut the zinc from the other side while you are sleeping. The second thing is the bar is not licensed. The third thing is there is no income to have security in place.*

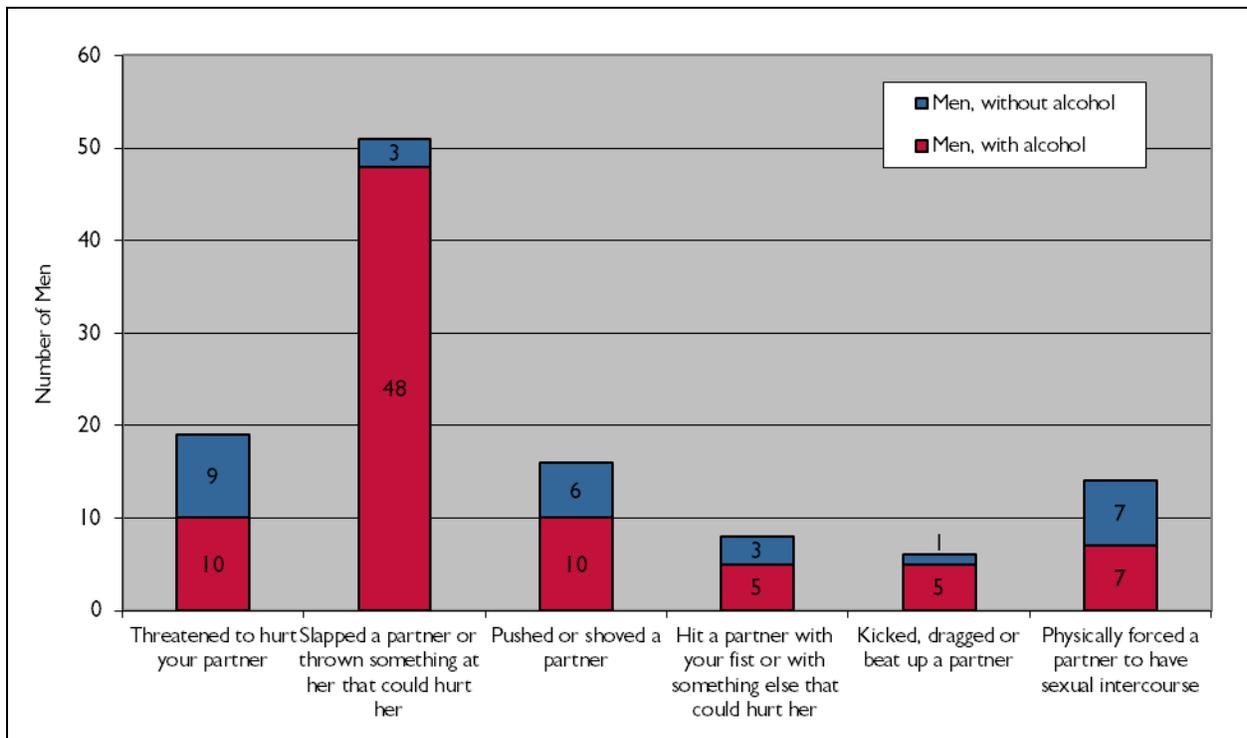
—Male bar owner, in-depth interview

Survey responses also show links between alcohol and intimate partner violence (see Figures 1 and 2). Both men and women reported that more partner violence occurred after drinking than not. Slapping was the most frequent type of violence reported in the past 12 months. Forced sex was much less common overall, but two-thirds of the women who reported forced sex had consumed alcohol prior to the experience, whereas half of the men who reported perpetrating forced sex had consumed alcohol beforehand.

**Figure 1. Alcohol and Partner Violence: Number of Drinking and Non-Drinking Women Reporting Experience of Violence by Type**



**Figure 2. Alcohol and Partner Violence: Number of Drinking and Non-Drinking Men Reporting Perpetration of Violence by Type**



## HIV KNOWLEDGE, ATTITUDES, AND BEHAVIORS

**Partners and sexual risk behavior:** Survey participants were asked for information on partners, including the number of sexual partners in the past six months. For each partner, they were asked about frequency of sex, condom use, and whether they were drunk the last time they had sex. The 359 sexually active respondents had a total of 600 partners, an average of 1.3 partners per respondent. The majority of partners (60 percent) were identified as girlfriends or boyfriends, followed by casual partners (25 percent), wives or husbands (11 percent), and a very small proportion of one-night stands and commercial partners.

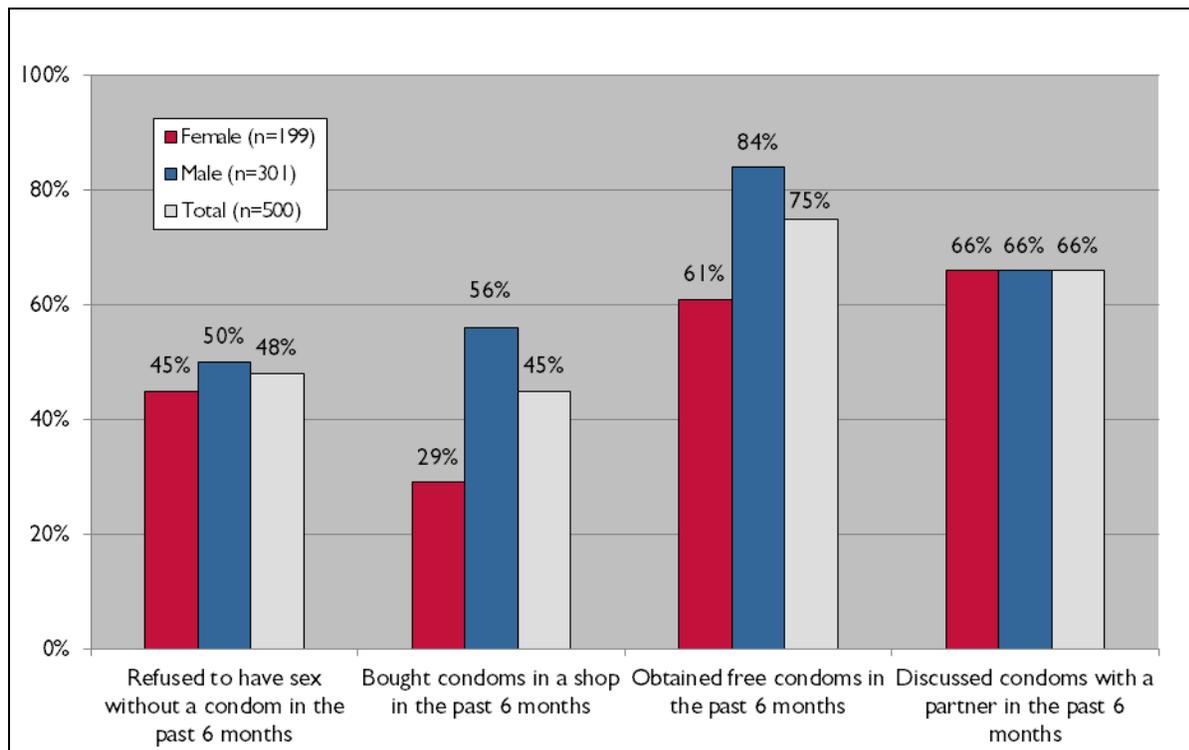
Respondents most frequently reported sex with their spouse, with whom they did not use a condom. They reported being drunk during sex with their spouses 13 percent of the time (see Table 5). This information is useful to the AIDSTAR-One project team for several reasons, including that it provides insight into the sexual risk behavior of bar patrons that can be targeted through the intervention as well as to track any changes that may occur during the intervention period.

**Table 5. Men and Women’s Sexual Encounters in the Past Six Months, According to Condom Use and Alcohol Use**

<b>Type of Partner</b>	<b>Median Number of Times Slept with in Last Six Months</b>	<b>Median Number of Times Used Condom in Last Six Months</b>	<b>Drunk at Last Sex (%), n = 600</b>
<b>Wife/husband</b>	38	0	13
<b>Girlfriend/boyfriend</b>	20	9	29
<b>Casual</b>	10	8	51
<b>One off/one-night stand</b>	1	1	56
<b>Commercial (sex worker)</b>	2	1	50

**Condom use and intentions:** The survey included questions about bar patrons’ intention to use condoms, focusing on non-spousal relationships because of low condom use within established partnerships. However, several factors affected the likelihood of using a condom. While over 90 percent of respondents felt that they had complete control about whether they used a condom, a lower proportion (28 percent of women and 10 percent of men) thought it likely that they would use a condom after they or their partner had been drinking alcohol. Also, only 45 percent of women and 50 percent of men reported that they had refused to have sex without a condom in the past six months (see Figure 3).

**Figure 3. Condom Use Intentions and Behaviors**



**Transactional sex:** The survey revealed a number of practices related to transactional sex, including sex with a sex worker and sex in exchange for goods, money, or alcohol. For the analysis, a variable was constructed based on participants' responses about whether they provided or received goods in exchange for sex (e.g., food, clothes, cell phone, school fees, residence fees, cosmetics, money for beauty products, and items for the family). Responses when the man gave, or the woman received, alcohol or money for sex were recorded separately. The most frequent transaction involved sex in exchange for money (49 percent), followed by exchange for goods or a place to stay (44 percent) and exchange for alcohol (38 percent). Women reported less transactional sex overall; the most frequent transaction involved sex in exchange for things or a place to stay (26 percent), followed by exchange for alcohol (25 percent) and exchange for money (10 percent). This information is relevant for the intervention because it highlights the importance of alcohol in transactional sex.

**Knowledge and attitudes about HIV:** The survey showed widespread variations in knowledge and perceptions about HIV and STIs. While most men and women knew that a healthy-looking person can have HIV, and that there is no cure for HIV (91 percent and 88 percent, respectively), 45 percent of women and 27 percent of men agreed with the statement, "[Unused] condoms can contain HIV." A low proportion of men and women knew that withdrawing the penis before ejaculation does not prevent a man from getting HIV. Knowledge of condoms was higher: 86 percent of survey respondents knew that using condoms can reduce the chance of getting HIV, and over 80 percent felt that condoms were reliable.

Treatment-seeking behavior, both for HIV and STIs, was similarly variable. A total of 22 percent of survey respondents reported any STI symptoms, mainly burning during urination, itching, and swelling (11 percent of women and 9 percent of men). Only 12 percent of these people sought

treatment (8 of the 11 men who reported penile discharge and 14 of the 21 women who reported a sore or ulcer). More women than men had ever had an HIV test (77 percent versus 46 percent, respectively); 43 percent of all respondents reported having an HIV test in the past 12 months.

## **ADDRESSING THE LINKAGE BETWEEN ALCOHOL USE AND HIV RISK**

**Bars and sexual behavior:** Respondents clearly linked going to bars with sexual opportunity. Both women and men reported that they had obtained condoms at a bar during the past six months. The survey showed that men were much more likely than women to want to meet a sexual partner at the bar (42 percent versus 12 percent). Over one-third of respondents felt that it was possible to find people willing to exchange money for sex in the bars (38 percent said often or always) or to exchange sex for drinks (32 percent reported that this occurred often).

In in-depth interviews, some bar patrons recognized the association between alcohol and sexual risk behavior, as well as that people taking antiretrovirals should reduce or avoid drinking alcohol:

*The only way to fight HIV is just to limit our alcohol and use condoms. For example a person is drunk and has HIV and sometimes she is missing her [antiretroviral] dose because of alcohol and sometimes people go to sleep and wake up with hangover and miss their doses.*

*—Female bar patron, in-depth interview*

**Role of bar owners in reducing excessive drinking and preventing risky sex:** Bar owners were also asked specifically about their actual or potential role in reducing heavy drinking or promoting HIV risk reduction among patrons. Regarding the promotion of HIV risk reduction, most bar owners expressed a lack of empowerment to do more than keep free condoms available and mentioned no other strategies they thought could be helpful.

*They just put condoms in their pockets but you don't know if they are going to use them.*

*—Female bar server, focus group discussion*

Regarding how bar owners might reduce heavy or binge drinking, bar patrons participating in the interviews did not feel that bar owners would be willing to stop serving people who are already drunk, a key strategy in safe serving practice to reduce harm from drinking (Gliksman et al. 1993).

*Bar owners won't want to reduce the amount of alcohol their patrons consume because it will affect their profits because they get money when people are drinking too much.*

*—Male bar patron, in-depth interview*

For their part, bar owners largely felt that patrons should be responsible for their own drinking patterns.

*By drinking too much it depends on the buyer. Seller has nothing to do because a person drink one to two beers and gets drunk, he will just tell the seller he drinks with his own money. Even if you tell them it's late and that they must go home they will just tell you that they use their money. We are not drinking for free unless you are not selling. Bar owners also want money so you can just sell.*

*—Male bar owner, in-depth interview*

Another key strategy in reducing alcohol-related harm is to establish strict closing hours (Stockwell and Chikritzhs 2009). Patrons, community members, and owners all mentioned that bars in Kabila

are open too late. Establishing a closing time or reduced hours of services could reduce the problems associated with alcohol, including heavy drinking, violence, and noise. However, without regulations or enforcement, most bar owners feel little incentive to close. A female community member suggested that bar owners address this issue by meeting together and agreeing to reduce their hours.

## ALCOHOL SELLING AS A LIVELIHOOD AND ALTERNATIVES

The strategies that households develop to ensure their economic survival depend on how their assets<sup>7</sup> combine with policies, institutions, and the vulnerability context in which they live. Income generation, well-being, and food security depend on these livelihood strategies.<sup>8</sup>

In considering livelihoods, researchers for this study assumed that poverty is a social driver of the HIV epidemic. This effect is exacerbated in Kabila, where many people earn an income by producing and selling alcohol. The research sought to clarify how Kabila residents viewed the constraints and opportunities for building better and more sustainable livelihoods. A specific interview guide was used to better understand the livelihood options of people living in Kabila. This interview guide was used with four men and four women. Specific issues around livelihoods were addressed in this guide, and questions were asked of all of the participants from Kabila about poverty and the lack of employment opportunities. Given that poverty results from structural problems, it is necessary to consider ways to build the capacity of residents of Kabila to have more confidence to initiate change, implement their own development activities, and engage in partnerships and dialogue with public authorities. Local residents consistently identified the government—in the form of the municipality—as the primary actor that could support them in their efforts to find better livelihoods.

**Income, work, and skills—the big picture:** Survey participants made their living by a combination of income sources, including full- and part-time salaried employment, self-employment, and assistance—financial and in-kind—from friends or family.<sup>9</sup> Here, gender differences abound. Women depend more often on their partners and on child maintenance (child support), while men are more often employed full-time with a salary or depend on family members for their income. Only one person, a man, identified himself as unemployed (see Table 6).

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<sup>7</sup> Assets include 1) human capital: skills, knowledge, and access to information; 2) social capital: formal and informal social relationships, networks, etc.; 3) natural capital: natural resources, including their flows and services; 4) physical capital: producer goods and physical infrastructure; and 5) financial capital: financial resources, including remittances and credit and loan systems. This is based on a model presented by New Zealand's International Aid & Development Agency (2006).

<sup>8</sup> More information about livelihood strategies is available at: [www.fao.org/docrep/006/y5084e/y5084e04.htm](http://www.fao.org/docrep/006/y5084e/y5084e04.htm)

<sup>9</sup> According to the International Labour Organization's *International Classification of Status in Employment*, 1) self-employment jobs are those jobs where the remuneration is directly dependent on the profits (or the potential for profits) derived from the goods and services produced, and the incumbents make the operational decisions affecting the enterprise (one-person operations); and 2) paid/waged employment jobs are those jobs where the incumbents hold explicit (written or oral) or implicit employment contracts that give them a basic remuneration not directly dependent on the revenue of the unit for which they work (this unit can be a corporation, a non-profit institution, a government unit or a household). Some or all of the tools, capital equipment, information systems, and/or premises used by the incumbents may be owned by others, and the incumbents may work under direct supervision of the owner(s). Paid employment jobs are typically remunerated by wages and salaries, but may be paid by commission from sales, by piece-rates, and in-kind payments such as food, housing, or training.

**Table 6. Sources of Income by Gender**

	<b>Women % (n)</b>	<b>Men % (n)</b>
<b>Unemployed</b>	0	0.3 (1)
<b>Employed, full-time (salary)</b>	26.6 (53)	41.5 (124)
<b>Employed, part-time/casual</b>	14.6 (29)	11.0 (33)
<b>Self-employed</b>	31.7 (63)	27.1 (81)
<b>From my partner</b>	15.1 (30)	1.7 (5)
<b>From my family</b>	8.5 (17)	15.1 (45)
<b>From friends</b>	0	0.3 (1)
<b>Pension</b>	0.5 (1)	1.0 (3)
<b>Child maintenance (child support)</b>	1.0 (2)	0
<b>In-service training</b>	1.0 (2)	0.3 (1)
<b>Disability fund</b>	0	1.0 (3)

The high proportion of self-employed and casual or part-time workers in Kabila reflects a worldwide phenomenon (Beneria 2001). Migration due to economic hardship and the impact of the HIV pandemic tends to increase the number of people who enter the informal economy. Other reasons usually mentioned are the demand for low-cost goods and services and the limited capacity of agriculture and the formal economy to absorb surplus labor explained by the increase of job seekers due to population growth and urbanization (Becker 2004). All of these trends are evident in Kabila.

The occupations in the self-employed category in Kabila are mainly informal activities, such as selling food and owning or operating a bar or a business.

**Informal livelihoods in Kabila:** Bars provide the most profitable income-generating activity in Kabila, but their profits are not high. A few bars in Kabila are owned by investors who do not reside in Kabila. These bars are generally set up in separate shacks and are licensed to sell alcohol, with mostly male patrons. In these bars, staff usually sleep in the building at night for security. These bars are usually better stocked and more profitable than others. Far more common are the informal bars that are set up as an extension of the home, selling alcohol as well as other commonly needed items such as snack food, soap, or *mielie* meal (maize meal—the staple carbohydrate that is used to make porridge). This may occur because of the absence of marketplaces in Kabila. These bars function more as gathering places for men and women of all ages, as well as children. They are operated and owned by local residents who lack financial resources to stock them well.

Bar owners assessed alcohol (mostly beer) as their most profitable good, followed by other essential and much demanded items including household items such as soap and toilet paper.<sup>10</sup>

**Bars:** One of the main reasons why owning a bar is perceived as the most profitable business is because its inputs and start-up costs are relatively inexpensive. Bars are stocked with beer from local

<sup>10</sup> In the field guide, people were asked to rank income-generating activities in order of profitability and stability. No information about actual profit margin was collected.

breweries and other goods are bought from wholesalers. Having a bar in addition to a waged or salaried position is seen as a good strategy to increase income security. Most salaried employees are paid at the end of the month, while a bar is a source of more consistent income.

In the economic hierarchy of the community, residents with stable jobs are perceived as enjoying a better life, followed by bar owners and meat sellers. However, the choice of owning a bar or working at a bar seems to be forced by the lack of labor opportunities:

*There is nothing else that I can do...because I don't work and the business is all I have.*

*—Male bar owner, in-depth interview*

*Anyone can ask you to sell for them in their bar for that month and then I get something so I can buy myself clothes and put a little in my account and help my child pay school fees. The times I get a job to sell in the bar and get N\$300 (U.S.\$40) then I save...there are no other jobs. If I don't work in a bar I am just home.*

*—Female bar patron, in-depth interview*

Furthermore, compared to bar owners, bartenders frequently mentioned that they experience an absence of food security and lack a sense of well-being:

*For example there is a woman there selling in the bar but she just got N\$250 (U.S.\$33) and she has kids to support but the owner makes more money out of the bar...In the bar you come to work every day, but you get a little salary. The owners of the bar make a lot of money but they don't want to pay their workers...in the bar you don't get paid when you are on leave, no social security, nothing.*

*—Female bar staff, focus group discussion*

**Women's informal employment:** Informal employment in Kabila emerges as a byproduct of exclusion from the labor market due to absence of skills (see subsequent section on education, skills, and training).<sup>11</sup> This exclusion pushes groups of workers, especially women, into other work. One of the main sources of income for women is selling a variety of perishable foods such as fruits and vegetables, meat, chicken, and fish.<sup>12</sup> Small pieces of cooked beef, known locally as *kapana*, are commonly sold in outdoor stands or next to bars. Other commercial informal activities include selling beans, *mahangu* (millet flour, a cereal staple), mielie meal, lemon water, and Amarula drink. All of these are harvested in the northern regions of Namibia and brought to Kabila to be sold.

*December I go to North. Then I stay there [until] April. After I'm done with field work then I go back again for the last harvest. I come back with Amarula drink to sell and then I come back to sell my kapana.*

*—Female bar patron, in-depth interview*

**Occupation, wages, and gender:** There is abundant evidence of stark gender inequalities in occupations, income, and reproductive choices. Women are mostly engaged in petty trade, bartending, childrearing, and keeping house. Men, on the other hand, mostly own bars and run the most significant commercial transactions and/or work in construction.

*I think it's a little bit easier for (a) man compared to a woman [to own a business or work in construction] because only a few women have the courage to say "I can do it" compared to men. That's why if you go there you see most of the businesses, only men are running them compared to women.*

*—Male bar owner, in-depth interview*

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<sup>11</sup> For a full analysis of the "exclusion" and "exit" dimensions on informality, see Guillermo et al. (2007).

<sup>12</sup> Women buy their stock of meat in nearby locations. They buy other perishable goods such as fruits and vegetables in the north of the country or from wholesalers that trade harvested fruits from the north.

Furthermore, the perception is that men make better profits than women.

*Men (benefit more) because women may have one crate of beer people won't buy, but most men own bars, and people supporting bars, they drink till late or until the police come push them out.*

*—Female community member, focus group discussion*

Women also earn less money, though this could be attributed to women's concentration in less profitable occupations. In the bars, women are relegated to lower income activities, mostly as bartenders.

In addition, there seems to be a perception that more women than men are unemployed, which speaks to women's higher level of economic vulnerability.

*I see the problem for this community is there is a lot of people and most of them are ladies and they don't have jobs. Sometimes they just walk around in the streets drunk, smoking, and just fighting after they get drunk or after smoking...Because there are few jobs, all night and day most of them are just ladies in the street.*

*—Female community member, in-depth interview*

**Education, skills, and training:** In Namibia, there is a close relationship between lack of skills or education and unemployment, especially for those leaving school with no training.<sup>13</sup> Interviewees described themselves as having minimal skills, and most pointed to the need for more training, especially certification in locally marketable skills. Men brought up construction skills and women mentioned tailoring—again reflecting a gender-related division of roles, where women are in charge of all tasks related to the family and men are expected to work outside the home. The general picture is that Kabila residents lack technical skills and are clustered in low-end, low-paying, low-productivity, low-quality occupations.<sup>14</sup> Because their skills have limited market value, and most Kabila residents lack certification in the skills they have, they are at high risk for unemployment, which forces them into informal work—such as working at a bar.

**Alternative livelihoods:** Kabila residents expressed interest in skill-building opportunities to strengthen their livelihood strategies. Women asked for “needle” and cooking courses. They are also interested in working as school teachers or having their own gardens (orchards to sell produce). Men want to be certified or licensed for construction work. Both men and women mentioned that they wanted training in business management and computer operation.

Interviewees also mentioned another aspect of skill building: developing ways in which local residents can mobilize around their own problems, in partnership with local authorities and other partners.

*The information we need is to be told or given a place where we can [come] together and talk about how to build up our business.*

*—Male bar owner, in-depth interview*

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<sup>13</sup> The 2000 Namibia Labor Force Survey estimated the unemployment rate at 34 percent and as particularly high for youth and for the unskilled (56 percent and 40 percent, respectively; World Bank 2005).

<sup>14</sup> This pattern emerges at the national level: partly because of a persistent “skills shortage,” Namibia creates low-paying jobs at a very high cost—mostly as labor and health risks are solely absorbed by the government (World Bank 2005).

# STUDY LIMITATIONS

The data presented here has several limitations. The main limitation results from the self-report method required by the survey. As with any survey requiring self-report, social desirability bias can be a limitation. In this survey, personal questions about sexual relationships, alcohol consumption, and violence could all have been affected by this particular bias. A second limitation is that the survey data were only collected from bar patrons. While this is the target population of the intervention, it cannot be assumed that bar patrons are representative of all community members.



# PROGRAM IMPLICATIONS AND NEXT STEPS

The formative research undertaken in the first phase of this project was specifically intended to inform the design of the program intervention and the monitoring and evaluation plan. This section reviews the three intervention components originally proposed in light of the findings from this formative research.

## **STRATEGY I: CREATING AN HIV-RISK AVERSE BAR ENVIRONMENT**

Findings from the formative research data showed a clear need to reduce risks within the bar environment: interviewees described bars as unsafe in that patrons were vulnerable to hazardous drinking, risky sexual behavior, violence, and theft, with women especially vulnerable. Bar owners and employees did not see themselves as able to address these risks for several reasons, including economic barriers and lack of infrastructure support, such as public services.

The health and safety risks described by participants support the need to help bar owners see themselves as agents of change in addressing excessive alcohol consumption. Community members felt that bar owners should (and could) help to address the negative effects of alcohol use.

The original concept proposed creating a risk averse bar arrangement through two components: 1) training bar owners and staff to serve alcohol more safely and to provide information to bar patrons on the hazards of excessive alcohol consumption and ways of reducing HIV risk, and 2) altering the physical attributes of the bars to make them more conducive to moderate alcohol consumption and HIV risk reduction.

Training on safe serving and HIV risk reduction will give bar owners knowledge and skills to communicate with their clients about hazardous alcohol consumption and encourage safer sex. Training will take place in groups, which will also provide a mechanism for bar owners to support each other, recognizing each other as colleagues rather than simply competitors, and addressing common problems, such as the pressure on bar owners regarding closing while other bars stayed open. The training will help bar owners to address community concerns and contribute to the solution of community problems. Secondly, the AIDSTAR-One team will help bar owners reduce risks in their establishments by assessing the products that they sell (for example, encouraging the sale of non-alcoholic beverages and food in addition to alcohol), developing strategies to ensure that condoms are always available, and replacing or augmenting alcohol advertisements with information about hazardous alcohol consumption and HIV risk reduction.

This project cannot directly address such problems as lack of infrastructure, including inadequate lighting and sanitation. However, the training will encourage bar owners to view their role as business people with a responsibility to their customers. Because many of the bars are also homes,

making the environment safer for patrons will also make conditions safer for the people who work and live there.

## **STRATEGY 2: MOBILIZING THE COMMUNITY FOR SELF-REGULATION**

The absence of governmental oversight means that communities themselves must find ways to self-regulate, which implies examining the effect of alcohol consumption, setting expectations about how bars will operate, and holding bar operators to those expectations. Interviewees articulated a desire for self-mobilization, and the example of the women's credit arrangement shows that self-organization is possible. However, participants did not mention how the community would take part in mitigating the negative effects of alcohol use. Suggestions were made about strategies such as reducing bars hours, but with the caveat that this would be impossible to implement without enforcement by governmental authorities. Clearly, encouraging community members to mobilize for action needs to be a primary focus for the success of this program. The original concept proposed a community action forum in which these issues could be addressed. Community members participating in the forum would receive the same training as bar owners. The exact content and form of the activities would be defined by the community, but could include community enforcement of common bar closing hours, organizing of community recreation activities as alternatives to drinking, or organizing a neighborhood business association that could help community members develop alternative cooperative business activities.

This component addresses the sense of isolation and abandonment that many interviewees expressed; indeed, drinking, for many interviewees, was a way of coping with these problems. By facilitating community mobilization, and building community members' capacity to advocate for their collective interests, the project can begin to address the context in which hazardous drinking occurs in Kabila. The community forum will help the intervention team and community members work with local government, civil society organizations, and other stakeholders, discussing issues and developing solutions. In particular, the intervention will help provide eligible community members with information and linkages with inpatient or outpatient treatment programs for alcohol dependency. Perhaps most importantly, the community mobilization component of the intervention may build a foundation for sustainable change that will outlive the 2.5-year project timeline.

## **STRATEGY 3: DECREASING THE TOTAL NUMBER OF BARS OPERATING IN THE COMMUNITY BY PROMOTING ALTERNATIVE LIVELIHOODS**

The formative research showed that bars are ubiquitous in Kabila because selling alcohol, while it does not produce great amounts of revenue, does provide a reliable income that is seen as the most lucrative business available to Kabila residents. Those selling alcohol often do so because they lack the skills, training, or capital to do anything else. The vast majority of bars are owned by men, while women comprise the greater number of those informally employed to serve the alcohol. Many research participants indicated they would prefer to earn an income by having a formal job but lacking that, many people showed an interest in other types of income-generating activities, ranging from community gardens to formal training in a skill or trade.

The original project description specified helping bar owners identify and move into more lucrative, less harmful work. This would entail working with local vocational training centers and relevant nonprofit organizations to refer participating bar owners to alternative livelihoods training, and possibly providing conditional cash transfers to bar owners to compensate them for loss of income during their transition to a new livelihood. The plan outlines documenting how participants use their training and whether the new livelihoods are having an effect—specifically, decreasing the total number of bars operating in the community.

Conducting training for alternative livelihoods would be an ambitious intervention that would require intensive financial resources to accomplish even on a small scale. While an alternative livelihoods intervention may hold promise, the information gained in the formative research leads to the conclusion that it is not feasible to pursue as part of this demonstration project. In addition to its high cost, there is a great potential for unintended consequences. For example, against the context of poverty and unemployment documented, it may be likely that enterprising bar owners would invest the resources gained from their new livelihoods to expand an existing bar or start a new one. Furthermore, if bars did go out of business as a result of the alternative livelihoods program, women's economic situations might worsen as they may lose jobs in serving; these jobs may not be replaced by other employment opportunities.

Given the potential importance of economic incentives for bar owners to participate in this demonstration project, the intervention will provide bar owners with information about how to improve their businesses. The training on safer serving practices and improving the safety of the bar environment will be delivered using an overarching concept of improving small business practices in addition to improving life in the community. In improving bar-owners' and servers' skills, the goal will be to help them understand their civic roles and responsibilities while helping them run better businesses. Furthermore, by working closely with bar owners in this way, the project team will have a unique opportunity to explore what types of messages are most meaningful and effective in incentivizing business owners to participate in a public health campaign. This information will be a valuable contribution to understanding how private business interests and the public interest can be brought into creative collaboration. Program monitoring and evaluation data from this demonstration project may thus inform future program development, including a possible pilot project focusing on alternative livelihoods.

Kabila presents excellent alternative retail opportunities; it contains no food stores and only a rudimentary market. Alcohol is readily available, but residents must travel outside the community for food and other essentials. There are also no community gardens or other cooperative business ventures aimed at provisioning Kabila's rapidly growing population with essential goods. With increased organization, training and some start-up capital, bar owners and servers may be able to establish alternative businesses, thereby displacing home-based alcohol selling as the only income-generating activity in the community.

## **NEXT STEPS<sup>15</sup>**

As the final step of the formative research, community members, community leaders, and members of the Namibia PEPFAR Interagency Alcohol Initiative will be invited to consultative workshops designed to share the research results and solicit input on the intervention design.

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<sup>15</sup> At date of publication, all next steps have been completed.

SFH will present the main findings and conclusions of the formative research to representatives from the Ministry of Gender Equality and Child Development, the Ministry of Labor and Social Welfare, and MOHSS; the Namibian Shebeen Owners Association; and community members (particularly those who participated in the research), stakeholders, and gatekeepers, such as the constituency councilor.

The intervention design workshops will ask participants to respond to the research findings, to suggest additional or alternative interpretations of the data, and to propose feasible and effective activities aimed at reducing the negative community health consequences of alcohol consumption. The intervention design workshops will be held over four weeks and will also work to manage expectations for what the intervention will address (e.g., the project cannot address infrastructure deficiencies). The primary goal of the workshops is to solicit ideas from community members about how they can address hazardous alcohol consumption. During the workshops, facilitators will share data from the formative research with community members and then facilitate a discussion on the challenges and solutions to hazardous alcohol consumption. The information gathered in these discussions will guide the development of the intervention and lay the groundwork for the community mobilization process.

With the completion of the workshops, the AIDSTAR-One team and SFH will draft the intervention protocol and monitoring framework in consultation with members of the PEPFAR Interagency Alcohol Initiative.

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